SLEOLA (JANUARY 1, 2014 TO DECEMBER 31, 2014)					
	Aetna				
Benefit	POS	POS	EPO In-Network		
	In-Network	Out-of-Network	in-inetwork		
Plan Year Deductible		easo.	I		
Individual		\$250	None		
Family Plan Year Out-of-Pocket Coinsurance & Deductible	None	<u> </u> \$500	None		
Combined Maximum	Any charges above the plan's	Allowed Benefit are not counted toward	s the out-of-pocket maximum.		
Individual	None	\$3,000	None		
Family	None	\$6,000	None		
Plan Year Copayment Out-of-Pocket Maximum					
Individual	\$1,000	None	\$1,000		
Family	\$2,000	None	\$2,000		
Lifetime Maximum		Unlimited			
National Network	Yes	Yes	Yes		
Primary Care Physician Required	No	No	Yes		
COMMON AND PREVENTIVE SERVICES					
Primary Care Physician's (PCP) Office Visit					
	\$15 copay	80% of allowed benefit after deductible	\$15 copay		
Specialist Office Visit	\$25 copay	80% of allowed benefit after deductible	\$25 copay		
	100% of allowed benefit	Not covered	100% of allowed benefit		
Adult Physical Exams & Associated Lab Work		year for all members and their dependen			
	100% of allowed benefit	Not covered	100% of allowed benefit		
Well Baby/Child Visits	Birth through 36 months -	up to 12 visits total; 3 through 21 years -	1 annual visit per plan year		
	Contact Aetna for further details on eligibility for visits.				
Immunizations* and Vaccines	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit		
and vaccines	20070 Or and Wed Seriem	Contact Aetna for a detailed list.	20070 Or another Seriem		
	\$15 copay (PCP) or \$25 copay		\$15 copay (PCP) or \$25 copay		
	(Specialists) for exam 100% of allowed benefit for Basic Model		(Specialists) for exam 100% of allowed benefit for Basic Model		
Hearing Examinations & Hearing Aids (No exam copay for children when part of well-	Hearing Aid	Not covered, except for hearing aids as mandated for minor children	Hearing Aid		
child visit.)	1 exam and hearing aid per ear every 3 years for each employee/retiree and	managed for minor ciniaren	1 exam and hearing aid per ear every 3 years for each employee/retiree and		
	dependent		dependent		
		or minor children (ages 0-18) as mandated			
Allergy Testing	\$15 copay (PCP) or \$25 copay (Specialists)	80% of allowed benefit after deductible	\$15 copay (PCP) or \$25 copay (Specialists)		
	(Specialists)	50% of anowed benefit after deductible	(Specialists)		
Nutritional Counseling & Health Education	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit		
		Contact Aetna for details.			
WOMAN'S SERVICES		<u> </u>			
	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit		
Well Woman Visits					
		ed on a women's health status, needs, an at are age and developmentally appropria			
	I	eling and interpersonal & domestic violence			
Mammography (Preventive)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit		
Mammography (Diagnostic)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit		
	20070 OF GHOWCU DEHELL	5575 of allowed beliefit after deductible	100/0 Of allowed beliefft		
In Vitro Fertilization (IVF) & Artificial Insemination	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit		
(AI)^^ (requires preauthorization)	lin to 2 attampts of N.F	Var Al par live hirth Contact Actual for for	urther details and limitations		
	100% of allowed benefit	/or AI per live birth. Contact Aetna for fu Not covered	100% of allowed benefit		
STI Screening & Counseling		creening for sexually active women as ma	l.		

	SLEOLA (JANUARY 1, 2014 TO	D DECEMBER 31, 2014)	
Benefit	Aetna POS In-Network	POS Out-of-Network	EPO In-Network
Contraceptive Counseling		Not Covered g, IUD insertion and tubal ligation. For info er to the Prescription Drug section of the o	
Family Planning & Fertility Testing	100% of allowed benefit Family planning benefits include	80% of allowed benefit after deductible : sperm count hysterosalpingography, eud	
Prenatal Care (Mandatated)	diabetes screening, tobacco ces	80% of allowed benefit after deductible s, all lab services explicitly identified in the ssation counseling specific to pregnant worrasounds) and high-risk prenatal services	e health reform law including gestational men, and certain immunizations.
Maternity Benefits	100% of allowed benefit	80% of allowed benefit after deductible services, hospital stay, and other postnata	100% of allowed benefit
Breastfeeing Support, Supplies & Counseling (in conjuction with each birth)	1	Not Covered certain breastfeeding equipment throughent partner(s). Contact Aetna for addition.	
THERAPIES (Preauthorization Required)	счирти	ent partner(s). Contact Actua for addition	ur details.
Benefit Therapies	\$25 copay	80% of allowed benefit after deductible	\$25 copay
Habilitative Services^^^	Covers childre	en under age 19 with congenital or genetion Not subject to 50 visits per plan year limit	
Physical Therapy (PT), Occupational Therapy (OT) & Speech Therapy HOSPITAL - INPATIENT SERVICES (Preautho	PT/OT/Speech Therapy; Speech Therapy special situ	after the 6th visit, based on medical neces y must be preauthroized from the first visi ations (e.g., trauma, brain injury) for add	ssity; 50 visits per plan year combine for t with exceptions and close monitoring for
Inpatient Care	100% of allowed benefit	80% of allowed benefit after deductible primarily for or solely for rehabilitation is	
Hospitalization	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Anesthesia	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Surgery	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Newborn Care****	100% of allowed benefit Contact Aetna to confirm your hospital not participate with the plan, you will be	80% of allowed benefit after deductible 's Neonatal Unit participates in the plan. I responsible for any balances up to the cha oviders under the out-of-network coverage these providers under the EPO plan.	100% of allowed benefit f the Neonatal Unit and its physicians do arge of the Neonatal Unit's providers. The
Organ Transplant	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
HOSPITAL - OUTPATIENT SERVICES	benefit is per calendar year for cornea,	kidney, bone marrow, heart, heart-lung, s	illigie of double lung, liver and pancreas.
Chemotherapy/ Radiation	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Outpatient Surgery (Preauthorization Required)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Anesthesia	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit

	SLEOLA (JANUARY 1, 2014 T	O DECEMBER 31, 2014)			
	Aetna				
Benefit	POS	POS	EPO		
	In-Network	Out-of-Network	In-Network		
EMERGENCY TREATMENT					
Urgent Care Centers	\$20 copay	80% of allowed benefit after deductible	\$20 copay		
Emergency Room (ER) Services - Inside and outside	\$50 copy for ER Facility plus \$50 for ER	\$50 copy for ER Facility plus \$50 for ER Physician Services	\$50 copy for ER Facility plus \$50 for ER Physician Services		
of service area ***	Copays are waived if admitted; if criteria are not met for a medical emergency, pla after two \$50 copays.		an coverage is 50% of allowed amount,		
Ambulance Services - Emergency Transport	100% of allowed benefit	100% of allowed benefit	100% of allowed benefit		
Ambulance Services - Non-Emergency Transport	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit		
OTHER SERVICES & SUPPLIES (Preauthoriza	tion Required)				
Acupuncture Services for Chronic Pain					
Management	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit		
Behavioral Health		ed by Aetna	Inpatient care: 100% of allowed benefit		
	See Behavioral He	alth Benefits Section.	Outpatient care: \$15 copay		
Cardiac Rehabilitation^	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit		
Chiropractic Services	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit		
Diagnostic Lab & X-Ray	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit		
	10070 OF UNOWED BEHEIT	50% of allowed benefit after deductible	100% of anowed benefit		
Durable Medical Equipment	100% of allowed benefit 80% of allowed benefit after deductible Contact Aetna for details on covered items				
Extended Care Facility	100% of allowed benefit	80% of allowed benefit after deductible	1		
	I -	facility benefits are limited to 180 days pe v. Inpatient care primarily for or solely for			
Home Health Care	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit		
Home Health Care		th Care benefits are limited to 120 days pe	ļ		
Hospice Care					
	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit		
	100% of allowed benefit	80% of allowed benefit after deductible			
Medical Supplies	_	dressings; casts; splints; syringes; dressing supplies for renal dialysis equipment and mandated by Maryland law.			
Outpatient Prescription Drugs		Covered separately from Plan.			
Outpatient Prescription Drugs		See Prescription Drug Benefits Section.	1		
Private Duty Nursing	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit		
Second Surgical Opinion (No Preauthroization Required)	100% of allowed benefit	100% of allowed benefit	100% of allowed benefit		
Whole Blood Charges (No Preauthroization	1000/ of allows - 1	200/ of allowed barrets at	1000/ of allows -l b fit		
Required)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit		
VISION SERVICES & SUPPLIES Vision Medical	\$15 conou (DCD) on \$35 conou				
Vision - Medical Any services that deal with the medical health of the eye.	\$15 copay (PCP) or \$25 copay (Specialists) (when rendered by Preferred Provider)	80% of allowed benefit after deductible	\$15 copay (PCP) or \$25 copay (Specialists)		
Vision - Routine	Exam: Plan pays up to \$45 (available once every plan year) Prescription lenses, frames, contact lenses (per plan year): \$200 every plan year per member (Member pays out-of-pocket				
Any services that deal with correcting vision.	and then submits a claim for reimbursement.) You may obtain vision services from any licensed vision provider, whether in the Aetna network or not. However, you m have to pay the full cost up front and submit a claim form to Aetna for partial reimbursement. Contact Aetna for more information.				
See Footnote Tab for Medical Footnotes					

	SLEOLA (J.	ANUARY 1, 2014 TO CAREFIRS		1)		
Benefit	PPO In-Network	PPO Out-of-Network	POS In-Network	POS Out-of-Network	EPO In-Network	
Plan Year Deductible						
Individual	None	\$250	None	\$250	None	
Family	None	\$500	None	\$500	None	
Plan Year Out-of-Pocket Coinsurance & Deductible Combined Maximum				towards the out-of-pocket n		
Individual		\$3,000	None	\$3,000	None	
Family Plan Year Copayment Out-of-Pocket Maximum	None	\$6,000	None	\$6,000	None	
Individual	\$1.000	None	\$1,000	None	\$1,000	
	\$2,000	None	\$2,000	None	\$2,000	
Lifetime Maximum	\$2,000	None	Unlimited	None	J. 2.,000	
National Network	Yes	Yes	No, Regional	Yes	Yes	
Primary Care Physician Required	No	No	Yes	No	No	
COMMON AND PREVENTIVE SER		NO	163	NO	140	
Primary Care Physician's (PCP) Office	VICES	200/ of allowed bounds		000/ of allowed bounds		
Visit	\$15 copay	80% of allowed benefit after deductible 80% of allowed benefit	\$15 copay	80% of allowed benefit after deductible 80% of allowed benefit	\$15 copay	
Specialist Office Visit	\$25 copay	after deductible	\$25 copay	after deductible	\$25 copay	
Adult Physical Exams & Associated Lab	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	Not covered	100% of allowed benefit	
Work		One exam per plan year fo	or all members and their de	pendents age 22 and older.	I.	
Well Deby (Child Visite	100% of allowed benefit	80% of allowed benefit after deductible		Not covered	100% of allowed benefit	
Well Baby/Child Visits	Birth through 36 months - up to 12 visits total; 3 through 21 years - 1 annual visit per plan year					
		Contact CareFi	rst for further details on eli	gibility for visits.		
Immunizations* and Vaccines	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	
		Con	tact CareFirst for a detailed	l list.	1	
	\$15 copay (PCP) or \$25 copay (Specialists) for exam	80% of allowed benefit after deductible for exam	\$15 copay (PCP) or \$25 copay (Specialists) for exam		\$15 copay (PCP) or \$25 copay (Specialists) for exam	
	100% of allowed benefit	100% of allowed benefit	100% of allowed benefit	Not covered, except for hearing aids as mandated for minor children	100% of allowed benefit	
Hearing Examinations & Hearing Aids (No exam copay for children when part	for Basic Model Hearing Aid	for Basic Model Hearing Aid	for Basic Model Hearing Aid		for Basic Model Hearing Aid	
of well-child visit.)	1 exam and hearing aid per ear every 3 years for each employee/retiree and dependent	1 exam and hearing aid per ear every 3 years for each employee/retiree and dependent	1 exam and hearing aid per ear every 3 years for each employee/retiree and dependent		1 exam and hearing aid per ear every 3 years for each employee/retiree and dependent	
				andated by Maryland law ef		
Allergy Testing	\$15 copay (PCP) or \$25 copay (Specialists)	80% of allowed benefit after deductible	\$15 copay (PCP) or \$25 copay (Specialists)	after deductible	\$15 copay (PCP) or \$25 copay (Specialists)	
Nutritional Counseling & Health Education	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	
MONANUS SERVICES			Contact CareFirst for detail	s.		
WOMAN'S SERVICES		000/ of allowed houseful		T		
Well Woman Visits	100% of allowed benefit	80% of allowed benefit after deductible		Not covered	100% of allowed benefit	
wen woman visits		are age and developmental		d risk factors. Allows wome conception counseling, tob ning & counseling.		
Mammography (Preventive)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	
Mammography (Diagnostic)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	
In Vitro Fertilization (IVF) & Artificial Insemination (AI)^^ (requires	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	
preauthorization)	Up to 3 a	ettempts of IVF and/or AI pe	er live birth. Contact CareFi	rst for further details and lin	mitations.	
STI Screening & Counseling	100% of allowed benefit	Not Covered	100% of allowed benefit	Not Covered	100% of allowed benefit	
	Counseling and screening for sexually active women as mandated by PPACA.					

	SLEOLA (J	ANUARY 1, 2014 TO CAREFIRS	DECEMBER 31, 2014 T	1)	
	PPO	PPO	POS	POS	EPO
Benefit	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Contraceptive Counseling			100% of allowed benefit		100% of allowed benefit
	Includes pre-conception of		d tubal ligation. For inform		ription contraceptives, refe
		80% of allowed benefit	rescription Drug section of t	80% of allowed benefit	1
	100% of allowed benefit	after deductible	100% of allowed benefit	after deductible	100% of allowed benefit
Family Planning & Fertility Testing					
	Family plann	ning benefits include: sperm	count hysterosalpingograp	hy, eudiometrical biopsy a	nd vasectomy.
		80% of allowed benefit		80% of allowed benefit	
	100% of allowed benefit	after deductible	100% of allowed benefit	after deductible	100% of allowed benefit
Prenatal Care (Mandatated)	Radiology	/ li e obstetrical ultrasoun	ds) and high-risk prenatal s	ervices may be subject to c	oincurance
			vices explicitly identified in seling specific to pregnant		
	Screen	80% of allowed benefit	iseling specific to pregnant	80% of allowed benefit	iizacions.
Maternity Benefits	100% of allowed benefit	after deductible	100% of allowed benefit	after deductible	100% of allowed benefit
iviaternity benefits		•	*	•	
		includes delivery service	s, hospital stay, and other p	Usuratai care and services.	
Breastfeeing Support, Supplies &	100% of allowed benefit	Not Covered	100% of allowed box-fit	Not Covered	100% of allowed benefit
Counseling (in conjuction with each	100% of allowed benefit		L.	Not Covered	
birth)	Covers the cost of renta	• •	stfeeding equipment throug		rable medical equipment
		partner(s).	Contact CareFirst for addit	ional details.	
THERAPIES (Preauthorization Re	quired)				
Benefit Therapies	\$25 copay when	80% of allowed benefit	\$25 copay when	80% of allowed benefit	\$25 copay when
	preauthorized by the Plan	after deductible	preauthorized by the Plan	after deductible	preauthorized by the Plan
					· · · · · · · · · · · · · · · · · · ·
Habilitative Services^^^ Physical Therapy (PT), Occupational	PT/OT services must be pr	Covers children und Not su reauthroized after the 6th v	er age 19 with congenital or bject to 50 visits per plan ye risit, based on medical neces	genetic birth defects. ear limit. ssity; 50 visits per plan year	
Physical Therapy (PT), Occupational Therapy (OT) & Speech Therapy	PT/OT services must be pr Therapy; Speech Therap	Covers children und Not su reauthroized after the 6th v by must be preauthroized fr traum	er age 19 with congenital or bject to 50 visits per plan ye	genetic birth defects. ear limit. ssity; 50 visits per plan year tions and close monitoring	
Physical Therapy (PT), Occupational	PT/OT services must be pr Therapy; Speech Therap	Covers children und Not su reauthroized after the 6th v by must be preauthroized fr traum uired)	er age 19 with congenital or bject to 50 visits per plan ye visit, based on medical nece- rom the first visit with excep	genetic birth defects. ear limit. ssity; 50 visits per plan year titions and close monitoring al visits.	
Physical Therapy (PT), Occupational Therapy (OT) & Speech Therapy HOSPITAL - INPATIENT SERVICES	PT/OT services must be pr Therapy; Speech Therap (Preauthorization Requ	Covers children und Not su reauthroized after the 6th v by must be preauthroized fi traum uired) 80% of allowed benefit	er age 19 with congenital or bject to 50 visits per plan ye isit, based on medical nece: om the first visit with excep ia, brain injury) for addition	genetic birth defects. ear limit. ssity; 50 visits per plan year titions and close monitoring al visits.	for special situations (e.g.,
Physical Therapy (PT), Occupational Therapy (OT) & Speech Therapy	PT/OT services must be pr Therapy; Speech Therap	Covers children und Not su reauthroized after the 6th v by must be preauthroized fr traum uired)	er age 19 with congenital or bject to 50 visits per plan ye visit, based on medical nece- rom the first visit with excep	genetic birth defects. ear limit. ssity; 50 visits per plan year titions and close monitoring al visits.	
Physical Therapy (PT), Occupational Therapy (OT) & Speech Therapy HOSPITAL - INPATIENT SERVICES	PT/OT services must be pr Therapy; Speech Therap (Preauthorization Requ	Covers children und Not su reauthroized after the 6th v by must be preauthroized fr traum uired) 80% of allowed benefit after deductible	er age 19 with congenital or bject to 50 visits per plan ye isit, based on medical nece: om the first visit with excep ia, brain injury) for addition	genetic birth defects. ear limit. ssity; 50 visits per plan year stions and close monitoring al visits. 80% of allowed benefit after deductible	for special situations (e.g.,
Physical Therapy (PT), Occupational Therapy (OT) & Speech Therapy HOSPITAL - INPATIENT SERVICES Inpatient Care	PT/OT services must be pr Therapy; Speech Therap (Preauthorization Requ	Covers children und Not su reauthroized after the 6th v by must be preauthroized fr traum uired) 80% of allowed benefit after deductible	er age 19 with congenital or bject to 50 visits per plan ye isit, based on medical nece: com the first visit with excep ia, brain injury) for addition	genetic birth defects. ear limit. ssity; 50 visits per plan year stions and close monitoring al visits. 80% of allowed benefit after deductible	for special situations (e.g.,
Physical Therapy (PT), Occupational Therapy (OT) & Speech Therapy HOSPITAL - INPATIENT SERVICES	PT/OT services must be pr Therapy; Speech Therap (Preauthorization Requ	Covers children und Not su reauthroized after the 6th v by must be preauthroized fr traum uired) 80% of allowed benefit after deductible Inpatient care prima	er age 19 with congenital or bject to 50 visits per plan ye isit, based on medical nece: com the first visit with excep ia, brain injury) for addition	genetic birth defects. ear limit. ssity; 50 visits per plan year titions and close monitoring al visits. 80% of allowed benefit after deductible itation is not covered.	for special situations (e.g.,
Physical Therapy (PT), Occupational Therapy (OT) & Speech Therapy HOSPITAL - INPATIENT SERVICES Inpatient Care Hospitalization	PT/OT services must be pr Therapy; Speech Therap (Preauthorization Requal 100% of allowed benefit	Covers children und Not su reauthroized after the 6th v ry must be preauthroized fr traum uired) 80% of allowed benefit after deductible Inpatient care prim: 80% of allowed benefit	er age 19 with congenital or bject to 50 visits per plan ye isit, based on medical nece: com the first visit with excep ia, brain injury) for addition 100% of allowed benefit arily for or solely for rehabil	genetic birth defects. ear limit. ssity; 50 visits per plan year stions and close monitoring al visits. 80% of allowed benefit after deductible itation is not covered. 80% of allowed benefit	for special situations (e.g.,
Physical Therapy (PT), Occupational Therapy (OT) & Speech Therapy HOSPITAL - INPATIENT SERVICES Inpatient Care	PT/OT services must be pr Therapy; Speech Therap (Preauthorization Requal 100% of allowed benefit	Covers children und Not su reauthroized after the 6th v ry must be preauthroized fr traum uired) 80% of allowed benefit after deductible Inpatient care prim: 80% of allowed benefit after deductible	er age 19 with congenital or bject to 50 visits per plan ye isit, based on medical nece: com the first visit with excep ia, brain injury) for addition 100% of allowed benefit arily for or solely for rehabil	genetic birth defects. ear limit. ssity; 50 visits per plan year stions and close monitoring al visits. 80% of allowed benefit after deductible itation is not covered. 80% of allowed benefit after deductible	for special situations (e.g.,
Physical Therapy (PT), Occupational Therapy (OT) & Speech Therapy HOSPITAL - INPATIENT SERVICES Inpatient Care Hospitalization Anesthesia	PT/OT services must be pr Therapy; Speech Therap (Preauthorization Requ 100% of allowed benefit	Covers children und Not su reauthroized after the 6th v ry must be preauthroized fi traum uired) 80% of allowed benefit after deductible Inpatient care prim: 80% of allowed benefit after deductible	er age 19 with congenital or bject to 50 visits per plan ye isit, based on medical necesom the first visit with excepa, brain injury) for addition 100% of allowed benefit arily for or solely for rehabil 100% of allowed benefit	genetic birth defects. ear limit. ssity; 50 visits per plan year stions and close monitoring al visits. 80% of allowed benefit after deductible itation is not covered. 80% of allowed benefit after deductible 80% of allowed benefit	100% of allowed benefit
Physical Therapy (PT), Occupational Therapy (OT) & Speech Therapy HOSPITAL - INPATIENT SERVICES Inpatient Care Hospitalization	PT/OT services must be pr Therapy; Speech Therap (Preauthorization Requ 100% of allowed benefit	Covers children und Not su reauthroized after the 6th v ry must be preauthroized fi traum uired) 80% of allowed benefit after deductible Inpatient care prim: 80% of allowed benefit after deductible 80% of allowed benefit after deductible	er age 19 with congenital or bject to 50 visits per plan ye isit, based on medical necesom the first visit with excepa, brain injury) for addition 100% of allowed benefit arily for or solely for rehabil 100% of allowed benefit	genetic birth defects. ear limit. ssity; 50 visits per plan year stions and close monitoring al visits. 80% of allowed benefit after deductible itation is not covered. 80% of allowed benefit after deductible 80% of allowed benefit after deductible	100% of allowed benefit
Physical Therapy (PT), Occupational Therapy (OT) & Speech Therapy HOSPITAL - INPATIENT SERVICES Inpatient Care Hospitalization Anesthesia	PT/OT services must be pr Therapy; Speech Therap (Preauthorization Requ 100% of allowed benefit 100% of allowed benefit	Covers children und Not su reauthroized after the 6th v by must be preauthroized fr traum sired) 80% of allowed benefit after deductible Inpatient care prim: 80% of allowed benefit after deductible 80% of allowed benefit after deductible	er age 19 with congenital or bject to 50 visits per plan ye isit, based on medical necesom the first visit with excepa, brain injury) for addition 100% of allowed benefit 100% of allowed benefit 100% of allowed benefit 100% of allowed benefit	genetic birth defects. ear limit. ssity; 50 visits per plan year titions and close monitoring al visits. 80% of allowed benefit after deductible itation is not covered. 80% of allowed benefit after deductible 80% of allowed benefit after deductible 80% of allowed benefit after deductible 80% of allowed benefit	100% of allowed benefit 100% of allowed benefit 100% of allowed benefit
Physical Therapy (PT), Occupational Therapy (OT) & Speech Therapy HOSPITAL - INPATIENT SERVICES Inpatient Care Hospitalization Anesthesia	PT/OT services must be pr Therapy; Speech Therap (Preauthorization Requ 100% of allowed benefit 100% of allowed benefit	Covers children und Not su reauthroized after the 6th v by must be preauthroized fr traum sired) 80% of allowed benefit after deductible Inpatient care prim: 80% of allowed benefit after deductible	er age 19 with congenital or bject to 50 visits per plan ye isit, based on medical necesom the first visit with excepa, brain injury) for addition 100% of allowed benefit 100% of allowed benefit 100% of allowed benefit 100% of allowed benefit	genetic birth defects. ear limit. ssity; 50 visits per plan year titions and close monitoring al visits. 80% of allowed benefit after deductible itation is not covered. 80% of allowed benefit after deductible	100% of allowed benefit 100% of allowed benefit 100% of allowed benefit
Physical Therapy (PT), Occupational Therapy (OT) & Speech Therapy HOSPITAL - INPATIENT SERVICES Inpatient Care Hospitalization Anesthesia	PT/OT services must be pr Therapy; Speech Therap (Preauthorization Requ 100% of allowed benefit 100% of allowed benefit 100% of allowed benefit 100% of allowed benefit 100% of allowed benefit	Covers children und Not su reauthroized after the 6th v by must be preauthroized fr traum uired) 80% of allowed benefit after deductible Inpatient care prim: 80% of allowed benefit after deductible	er age 19 with congenital or bject to 50 visits per plan ye risit, based on medical necesom the first visit with excepta, brain injury) for addition 100% of allowed benefit 100% of allowed 1	genetic birth defects. ear limit. ssity; 50 visits per plan year tions and close monitoring al visits. 80% of allowed benefit after deductible sitation is not covered. 80% of allowed benefit after deductible plan. If the Neonatal Unit	100% of allowed benefit
Physical Therapy (PT), Occupational Therapy (OT) & Speech Therapy HOSPITAL - INPATIENT SERVICES Inpatient Care Hospitalization Anesthesia Surgery (requires preauthorization)	PT/OT services must be pr Therapy; Speech Therap (Preauthorization Requal 100% of allowed benefit 100%	Covers children und Not su reauthroized after the 6th v ry must be preauthroized fr traum uired) 80% of allowed benefit after deductible Inpatient care prim: 80% of allowed benefit after deductible sof allowed benefit after deductible sof allowed benefit after deductible sof allowed benefit after deductible onfirm your hospital's Neon you will be responsible for	er age 19 with congenital or bject to 50 visits per plan ye risit, based on medical necesom the first visit with excepta, brain injury) for additional process of allowed benefit arily for or solely for rehabil 100% of allowed benefit 100% of allo	genetic birth defects. ear limit. ssity; 50 visits per plan year stions and close monitoring al visits. 80% of allowed benefit after deductible sitation is not covered. 80% of allowed benefit after deductible god fallowed benefit after deductible plan. If the Neonatal Unit's profite Neonatal	100% of allowed benefit and its physicians do not providers. The PPO and PO
Physical Therapy (PT), Occupational Therapy (OT) & Speech Therapy HOSPITAL - INPATIENT SERVICES Inpatient Care Hospitalization Anesthesia Surgery (requires preauthorization)	PT/OT services must be pr Therapy; Speech Therap (Preauthorization Requal 100% of allowed benefit 100%	Covers children und Not su reauthroized after the 6th v ry must be preauthroized fr traum uired) 80% of allowed benefit after deductible Inpatient care prim: 80% of allowed benefit after deductible sof allowed benefit after deductible sof allowed benefit after deductible sof allowed benefit after deductible onfirm your hospital's Neon you will be responsible for	er age 19 with congenital or bject to 50 visits per plan ye isit, based on medical necesom the first visit with excepta, brain injury) for addition 100% of allowed benefit 10	genetic birth defects. ear limit. ssity; 50 visits per plan year stions and close monitoring al visits. 80% of allowed benefit after deductible sitation is not covered. 80% of allowed benefit after deductible god fallowed benefit after deductible plan. If the Neonatal Unit's profite Neonatal	100% of allowed benefit and its physicians do not providers. The PPO and PO
Physical Therapy (PT), Occupational Therapy (OT) & Speech Therapy HOSPITAL - INPATIENT SERVICES Inpatient Care Hospitalization Anesthesia Surgery (requires preauthorization)	PT/OT services must be pr Therapy; Speech Therap (Preauthorization Requal 100% of allowed benefit 100%	Covers children und Not su reauthroized after the 6th v by must be preauthroized fr traum lired) 80% of allowed benefit after deductible Inpatient care primi 80% of allowed benefit after deductible som of allowed benefit after deductible som of allowed benefit after deductible som of allowed benefit after deductible	er age 19 with congenital or bject to 50 visits per plan ye risit, based on medical necesom the first visit with excepta, brain injury) for additional process of allowed benefit arily for or solely for rehabil 100% of allowed benefit 100% of allo	genetic birth defects. ear limit. ssity; 50 visits per plan year titions and close monitoring al visits. 80% of allowed benefit after deductible itation is not covered. 80% of allowed benefit after deductible 90% of allowed benefit after deductible gof the Neonatal Unit's profits Neonatal Un	100% of allowed benefit and its physicians do not providers. The PPO and PO
Physical Therapy (PT), Occupational Therapy (OT) & Speech Therapy HOSPITAL - INPATIENT SERVICES Inpatient Care Hospitalization Anesthesia Surgery (requires preauthorization) Newborn Care****	PT/OT services must be pr Therapy; Speech Therap (Preauthorization Requal 100% of allowed benefit 100	Covers children und Not sureauthroized after the 6th vor must be preauthroized from traum suired) 80% of allowed benefit after deductible Inpatient care primater deductible 80% of allowed benefit after deductible	er age 19 with congenital or bject to 50 visits per plan ye isit, based on medical necesom the first visit with excepta, brain injury) for additional process of the first visit with excepta, brain injury) for additional process of allowed benefit arily for or solely for rehabil 100% of allowed benefit 100% of allowed	genetic birth defects. ear limit. ssity; 50 visits per plan year titions and close monitoring al visits. 80% of allowed benefit after deductible itation is not covered. 80% of allowed benefit after deductible 80% of allowed benefit after deductible 80% of allowed benefit after deductible god of allowed benefit after deductible 10% of allowed benefit 10% of allowed benefit	100% of allowed benefit and its physicians do not providers. The PPO and POS for these providers under
Physical Therapy (PT), Occupational Therapy (OT) & Speech Therapy HOSPITAL - INPATIENT SERVICES Inpatient Care Hospitalization Anesthesia Surgery (requires preauthorization) Newborn Care**** Organ Transplant (requires	PT/OT services must be pr Therapy; Speech Therap (Preauthorization Requal 100% of allowed benefit 100%	Covers children und Not su reauthroized after the 6th v by must be preauthroized fr traum lired) 80% of allowed benefit after deductible Inpatient care primi 80% of allowed benefit after deductible som of allowed benefit after deductible som of allowed benefit after deductible som of allowed benefit after deductible	er age 19 with congenital or bject to 50 visits per plan ye isit, based on medical necesom the first visit with excepta, brain injury) for addition 100% of allowed benefit 10	genetic birth defects. ear limit. ssity; 50 visits per plan year titions and close monitoring al visits. 80% of allowed benefit after deductible itation is not covered. 80% of allowed benefit after deductible 90% of allowed benefit after deductible gof the Neonatal Unit's profits Neonatal Un	100% of allowed benefit and its physicians do not providers. The PPO and POS
Physical Therapy (PT), Occupational Therapy (OT) & Speech Therapy HOSPITAL - INPATIENT SERVICES Inpatient Care Hospitalization Anesthesia Surgery (requires preauthorization) Newborn Care****	PT/OT services must be pr Therapy; Speech Therapy (Preauthorization Requal 100% of allowed benefit	Covers children und Not su reauthroized after the 6th v by must be preauthroized fr traum 11red) 80% of allowed benefit after deductible Inpatient care prima 80% of allowed benefit after deductible 180% of allowed benefit after deductible	er age 19 with congenital or bject to 50 visits per plan ye visit, based on medical necesom the first visit with excepta, brain injury) for additional process of the proce	genetic birth defects. ear limit. ssity; 50 visits per plan year tions and close monitoring al visits. 80% of allowed benefit after deductible itation is not covered. 80% of allowed benefit after deductible plan. If the Neonatal Unit's p There will be no coverage 80% of allowed benefit	100% of allowed benefit and its physicians do not providers. The PPO and POS for these providers under
Physical Therapy (PT), Occupational Therapy (OT) & Speech Therapy HOSPITAL - INPATIENT SERVICES Inpatient Care Hospitalization Anesthesia Surgery (requires preauthorization) Newborn Care**** Organ Transplant (requires preauthorization)	PT/OT services must be pr Therapy; Speech Therapy (Preauthorization Requal 100% of allowed benefit 10	Covers children und Not su reauthroized after the 6th v by must be preauthroized fr traum 11red) 80% of allowed benefit after deductible Inpatient care prima 80% of allowed benefit after deductible 180% of allowed benefit after deductible	er age 19 with congenital or bject to 50 visits per plan ye isit, based on medical necesom the first visit with excepta, brain injury) for additional process of the first visit with excepta, brain injury) for additional process of allowed benefit arily for or solely for rehabil 100% of allowed benefit 100% of allowed	genetic birth defects. ear limit. ssity; 50 visits per plan year tions and close monitoring al visits. 80% of allowed benefit after deductible itation is not covered. 80% of allowed benefit after deductible plan. If the Neonatal Unit's p There will be no coverage 80% of allowed benefit	100% of allowed benefit and its physicians do not providers. The PPO and POS for these providers under
Physical Therapy (PT), Occupational Therapy (OT) & Speech Therapy HOSPITAL - INPATIENT SERVICES Inpatient Care Hospitalization Anesthesia Surgery (requires preauthorization) Newborn Care**** Organ Transplant (requires	PT/OT services must be pr Therapy; Speech Therapy (Preauthorization Requal 100% of allowed benefit 10	Covers children und Not su reauthroized after the 6th v by must be preauthroized fr traum 11red) 80% of allowed benefit after deductible Inpatient care prima 80% of allowed benefit after deductible 180% of allowed benefit after deductible	er age 19 with congenital or bject to 50 visits per plan ye visit, based on medical necesom the first visit with excepta, brain injury) for additional process of the proce	genetic birth defects. ear limit. ssity; 50 visits per plan year tions and close monitoring al visits. 80% of allowed benefit after deductible itation is not covered. 80% of allowed benefit after deductible plan. If the Neonatal Unit's p There will be no coverage 80% of allowed benefit	100% of allowed benefit and its physicians do not providers. The PPO and POS for these providers under
Physical Therapy (PT), Occupational Therapy (OT) & Speech Therapy HOSPITAL - INPATIENT SERVICES Inpatient Care Hospitalization Anesthesia Surgery (requires preauthorization) Newborn Care**** Organ Transplant (requires preauthorization) HOSPITAL - OUTPATIENT SERVICE	PT/OT services must be pr Therapy; Speech Therapy (Preauthorization Requal 100% of allowed benefit 10	Covers children und Not su reauthroized after the 6th v by must be preauthroized fr traum 11red) 80% of allowed benefit after deductible Inpatient care prima 80% of allowed benefit after deductible 180% of allowed benefit after deductible	er age 19 with congenital or bject to 50 visits per plan ye visit, based on medical necesom the first visit with excepta, brain injury) for additional process of the proce	genetic birth defects. ear limit. ssity; 50 visits per plan year tions and close monitoring al visits. 80% of allowed benefit after deductible itation is not covered. 80% of allowed benefit after deductible plan. If the Neonatal Unit's p There will be no coverage 80% of allowed benefit	100% of allowed benefit and its physicians do not providers. The PPO and POS for these providers under
Physical Therapy (PT), Occupational Therapy (OT) & Speech Therapy HOSPITAL - INPATIENT SERVICES Inpatient Care Hospitalization Anesthesia Surgery (requires preauthorization) Newborn Care**** Organ Transplant (requires preauthorization)	PT/OT services must be pr Therapy; Speech Therapy (Preauthorization Requal 100% of allowed benefit 10	Covers children und Not su reauthroized after the 6th v by must be preauthroized fr traum 1	er age 19 with congenital or bject to 50 visits per plan ye visit, based on medical necesom the first visit with excepta, brain injury) for additional process of the proce	genetic birth defects. ear limit. ssity; 50 visits per plan year titions and close monitoring al visits. 80% of allowed benefit after deductible itation is not covered. 80% of allowed benefit after deductible 80% of allowed benefit after deductible 80% of allowed benefit after deductible 90% of allowed benefit after deductible plan. If the Neonatal Unit's g There will be no coverage 80% of allowed benefit after deductible the Neonatal Unit's g There deductible 80% of allowed benefit after deductible 180% of allowed benefit after deductible 180% of allowed benefit after deductible	100% of allowed benefit and its physicians do not providers. The PPO and PO of or these providers under
Physical Therapy (PT), Occupational Therapy (OT) & Speech Therapy HOSPITAL - INPATIENT SERVICES Inpatient Care Hospitalization Anesthesia Surgery (requires preauthorization) Newborn Care**** Organ Transplant (requires preauthorization) HOSPITAL - OUTPATIENT SERVICE	PT/OT services must be pr Therapy; Speech Therapy (Preauthorization Requal 100% of allowed benefit 10	Covers children und Not su reauthroized after the 6th v by must be preauthroized fr traum 1	er age 19 with congenital or bject to 50 visits per plan ye visit, based on medical necesom the first visit with excepta, brain injury) for additional process of the first visit with excepta, brain injury) for additional process of allowed benefit arily for or solely for rehabil 100% of allowed benefit 100% of allowe	genetic birth defects. ear limit. ssity; 50 visits per plan year tions and close monitoring al visits. 80% of allowed benefit after deductible itation is not covered. 80% of allowed benefit after deductible 80% of allowed benefit after deductible 80% of allowed benefit after deductible plan. If the Neonatal Unit's ge of allowed benefit after deductible	100% of allowed benefit and its physicians do not roviders. The PPO and POS for these providers under 100% of allowed benefit
Physical Therapy (PT), Occupational Therapy (OT) & Speech Therapy HOSPITAL - INPATIENT SERVICES Inpatient Care Hospitalization Anesthesia Surgery (requires preauthorization) Newborn Care**** Organ Transplant (requires preauthorization) HOSPITAL - OUTPATIENT SERVICE Chemotherapy/ Radiation	PT/OT services must be pr Therapy; Speech Therapy (Preauthorization Requal 100% of allowed benefit 10	Covers children und Not su reauthroized after the 6th v by must be preauthroized fr traum 1	er age 19 with congenital or bject to 50 visits per plan ye visit, based on medical necesom the first visit with excepta, brain injury) for additional process of the first visit with excepta, brain injury) for additional process of allowed benefit arily for or solely for rehabil 100% of allowed benefit 100% of allowe	genetic birth defects. ear limit. ssity; 50 visits per plan year titions and close monitoring al visits. 80% of allowed benefit after deductible itation is not covered. 80% of allowed benefit after deductible 80% of allowed benefit after deductible 80% of allowed benefit after deductible plan. If the Neonatal Unit's ge of the Neonatal Unit's There will be no coverage 80% of allowed benefit after deductible	100% of allowed benefit and its physicians do not roviders. The PPO and POS for these providers under 100% of allowed benefit
Physical Therapy (PT), Occupational Therapy (OT) & Speech Therapy HOSPITAL - INPATIENT SERVICES Inpatient Care Hospitalization Anesthesia Surgery (requires preauthorization) Newborn Care**** Organ Transplant (requires preauthorization) HOSPITAL - OUTPATIENT SERVICE Chemotherapy/ Radiation Outpatient Surgery (Preauthorization)	PT/OT services must be pr Therapy; Speech Therap (Preauthorization Requal 100% of allowed benefit	Covers children und Not su reauthroized after the 6th vor must be preauthroized from traum suired) 80% of allowed benefit after deductible Inpatient care primal summer after deductible 80% of allowed benefit after deductible sonfirm your hospital's Neon you will be responsible for providers under the out-of- 80% of allowed benefit after deductible dar year for cornea, kidney 80% of allowed benefit after deductible 80% of allowed benefit after deductible 80% of allowed benefit after deductible	er age 19 with congenital or bject to 50 visits per plan ye visit, based on medical necesom the first visit with excepta, brain injury) for additional loow of allowed benefit arily for or solely for rehabil 100% of allowed benefit	genetic birth defects. ear limit. ssity; 50 visits per plan year tions and close monitoring al visits. 80% of allowed benefit after deductible itation is not covered. 80% of allowed benefit after deductible 80% of allowed benefit after deductible 80% of allowed benefit after deductible plan. If the Neonatal Unit's ge the Neonatal Unit's ge There will be no coverage 80% of allowed benefit after deductible to the Neonatal Unit's ge allowed benefit after deductible 80% of allowed benefit	100% of allowed benefit and its physicians do not providers. The PPO and POS for these providers under 100% of allowed benefit g, liver and pancreas.

SLEOLA (JANUARY 1, 2014 TO DECEMBER 31, 2014) CAREFIRST					
Benefit	PPO In-Network	PPO Out-of-Network	POS In-Network	POS Out-of-Network	EPO In-Network
EMERGENCY TREATMENT	III-Network	Out-oi-Network	III-Network	Out-oi-Network	III-Network
		80% of allowed benefit		80% of allowed benefit	
Urgent Care Centers	\$20 copay	after deductible	\$20 copay	after deductible	\$20 copay
	\$50 copy for ER Facility	\$50 copy for ER Facility	\$50 copy for ER Facility	\$50 copy for ER Facility	\$50 copy for ER Facility
Emergency Room (ER) Services - Inside	plus \$50 for ER Physician	plus \$50 for ER Physician	plus \$50 for ER Physician	plus \$50 for ER Physician	plus \$50 for ER Physician
and outside of service area ***	Services	Services	Services	Services	Services
	Copays are waived if admi	tted; if criteria are not met	copays.	olan coverage is 50% of allo	wed amount, after two \$50
Ambulance Services - Emergency Transport	100% of allowed benefit	100% of allowed benefit	100% of allowed benefit	100% of allowed benefit	100% of allowed benefit
Ambulance Services - Non-Emergency		80% of allowed benefit		80% of allowed benefit	
Transport	100% of allowed benefit	after deductible	100% of allowed benefit	after deductible	100% of allowed benefit
OTHER SERVICES & SUPPLIES (Pre	authorization Required	d)			
Acupuncture Services for Chronic Pain		80% of allowed benefit		80% of allowed benefit	
Management	\$20 copay	after deductible	100% of allowed benefit	after deductible	100% of allowed benefit
		Not severe	I bu Cara Sinat		Inpatient care: 100% of allowed benefit
Behavioral Health			I by CareFirst Ith Benefits Section.		Outpatient care: \$15
					copay
Conding Dahahilitatian		80% of allowed benefit		80% of allowed benefit	. ,
Cardiac Rehabilitation [^]	100% of allowed benefit	after deductible	100% of allowed benefit	after deductible	100% of allowed benefit
Chiropractic Services		80% of allowed benefit		80% of allowed benefit	
emiopractic services	\$20 copay	after deductible	100% of allowed benefit	after deductible	100% of allowed benefit
Diagnostic Lab & X-Ray		80% of allowed benefit		80% of allowed benefit	
,	100% of allowed benefit	after deductible	100% of allowed benefit	after deductible	100% of allowed benefit
Durable Medical Equipment	100% of allowed benefit	80% of allowed benefit	100% of allowed benefit	80% of allowed benefit	100% of allowed banefit
Durable Medical Equipment	100% of allowed benefit	after deductible	100% of allowed benefit CareFirst for details on cove	after deductible	100% of allowed benefit
		80% of allowed benefit	areriist for details on cove	80% of allowed benefit	
	100% of allowed benefit	after deductible	100% of allowed benefit		100% of allowed benefit
Extended Care Facility			•	s per benefit period as long	
				for rehabilitation is not cov	
		80% of allowed benefit		80% of allowed benefit	
Home Health Care	100% of allowed benefit	after deductible	100% of allowed benefit	after deductible	100% of allowed benefit
		Home Health Care	benefits are limited to 120	days per plan year.	
Hospice Care		80% of allowed benefit		80% of allowed benefit	
	100% of allowed benefit	after deductible	100% of allowed benefit	after deductible	100% of allowed benefit
		80% of allowed benefit		80% of allowed benefit	
Medical Supplies	100% of allowed benefit	after deductible	100% of allowed benefit	after deductible	100% of allowed benefit
	Includes, but not limit	ed to, surgical dressings; ca	sts; splints; syringes; dressi	ngs for cancer, burns, or dia	abetic ulcers; catheters,
	colostomy bags; oxygen;	supplies for renal dialysis e	quipment and machines; ar	nd all diabetic supplies as m	andated by Maryland law.
Outpatient Prescription Drugs			Covered separately from Pla		
· · · · · · · · · · · · · · · · · · ·		See P	rescription Drug Benefits S	ection.	
Private Duty Nursing		80% of allowed benefit		80% of allowed benefit	
Connect Countries (No.	100% of allowed benefit	after deductible	100% of allowed benefit	after deductible	100% of allowed benefit
Second Surgical Opinion (No Preauthroization Required)	100% of allowed benefit	100% of allowed benefit	100% of allowed benefit	100% of allowed benefit	100% of allowed benefit
Whole Blood Charges (No	100/0 of allowed belieft	80% of allowed benefit	100% of anowed benefit	80% of allowed benefit	10070 of dilowed belieft
Preauthroization Required)	100% of allowed benefit	after deductible	100% of allowed benefit	after deductible	100% of allowed benefit
VISION SERVICES & SUPPLIES					
Vision - Medical Any services that deal with the medical	¢1E copay (BCB) or ¢2E	80% of allowed benefit	\$15 copay (PCP) or \$25	80% of allowed benefit	\$15 copay (PCP) or \$25
health of the eye.	copay (Specialists)	after deductible	copay (Specialists)	after deductible	copay (Specialists)
,		(available once every plan		I	
	Examination pays up to \$15	(available office every plan	yes. /	Single vision:	\$28.80
				Bifocal, single	\$48.60
	Prescription lenses (ner na	air - available once every pla	an vear):	Bifocal, double	\$88.20
		aranable office every pie	,,.	Trifocal	\$70.20
Vision - Routine				Aphakic - glass	\$54.00
Any services that deal with correcting vision.				Aphakic - plastic	\$126.00
risioth.				Aphakic - aspheric	\$162.00
	Frames: Plan pays up to \$4	15 (available once every pla	n year)	1	F.
	Contacts (per pair, instead	of frames and lenses - avai	lable once every plan	Medically Necessary	\$201.60
	year):			Cosmetic	\$50.40
	Vou may obtain dele-	vices from any list	on provider whather in the	CaroEiret naturali	However was man have
	•	•	•	 CareFirst network or not. bursement. Contact CareFire 	
See Footnote Tab for Medical Footnote		Sastine a ciaim form t	a.cac for partial reliff	- Jement Contact Careri	

PPO In-Network	PPO Out-of-Network	POS In-Network	POS Out-of-Network	EPO In-Network
None	6250	Nana	ėsro.	None
				None None
None	\$300	None	<u> </u>	ivone
	Any charges above the plan's A	llowed Benefit are not counted towar	rds the out-of-pocket maximum.	<u></u>
None	\$3,000	None	\$3,000	None
None	\$6,000	None	\$6,000	None
\$1,000	None	\$1,000	None	\$1,000
\$2,000	None	\$2,000	None	\$2,000
		Unlimited		
Yes	Yes	Yes	Yes	Yes
No	No	No	No	Yes
ES	80% of allowed benefit after		80% of allowed benefit after	
\$15 copay	deductible	\$15 copay	deductible	\$15 copay
\$25 conav		\$25 conav		\$25 copay
	80% of allowed benefit after		deddelible	
100% of allowed benefit		100% of allowed benefit rear for all members and their depends	Not covered ents age 22 and older.	100% of allowed benefit
	80% of allowed benefit after	ear for all members and their depends	ents age 22 and older.	
100% of allowed benefit	deductible	100% of allowed benefit	Not covered	100% of allowed benefit
	80% of allowed benefit after	dhealthcare for further details on elig	80% of allowed benefit after	
100% of allowed benefit	deductible	100% of allowed benefit	deductible	100% of allowed benefit
	Co	ntact UnitedHealthcare for a detailed	list.	
\$15 copay (PCP) or \$25 copay (Specialists) for exam	80% of allowed benefit after deductible for exam	\$15 copay (PCP) or \$25 copay (Specialists) for exam		\$15 copay (PCP) or \$25 copay (Specialists) for exam
100% of allowed benefit for Basic Model Hearing Aid	100% of allowed benefit for Basic Model Hearing Aid	100% of allowed benefit for Basic Model Hearing Aid	Not covered, except for hearing aids as mandated for minor children	100% of allowed benefit for Basic Model Hearing Aid
1 exam and hearing aid per ear every 3 years for each employee/retires and dependent	1 exam and hearing aid per ear every 3 years for each employee/retiree and dependent	1 exam and hearing aid per ear every 3 years for each		1 exam and hearing aid per ear every 3 years for each employee/retiree and dependent
employee/retiree and dependent			ed by Maryland law effective 1/1/02	employee/rearee and dependent
\$15 copay (PCP) or \$25 copay	80% of allowed benefit after	\$15 copay (PCP) or \$25 copay	80% of allowed benefit after	\$15 copay (PCP) or \$25 copay
(Specialists)		(Specialists)		(Specialists)
100% of allowed benefit	deductible	100% of allowed benefit	deductible	100% of allowed benefit
		Contact UnitedHealthcare for details		
	80% of allowed benefit after			
100% of allowed benefit	deductible	100% of allowed benefit	Not covered	100% of allowed benefit
	ncluding preconception counseling, tol			
100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	deductible	100% of allowed benefit
	deductible 80% of allowed benefit after		deductible 80% of allowed benefit after	
100% of allowed benefit	deductible 80% of allowed benefit after deductible 80% of allowed benefit after	100% of allowed benefit	deductible 80% of allowed benefit after deductible 80% of allowed benefit after	100% of allowed benefit
	deductible 80% of allowed benefit after deductible		deductible 80% of allowed benefit after deductible	
100% of allowed benefit 100% of allowed benefit	deductible 80% of allowed benefit after deductible 80% of allowed benefit after deductible Up to 3 attempts of IVF and/or AI p	100% of allowed benefit 100% of allowed benefit per live birth. Contact UnitedHealthcar	deductible 80% of allowed benefit after deductible 80% of allowed benefit after deductible re for further details and limitations.	100% of allowed benefit 100% of allowed benefit
100% of allowed benefit	deductible 80% of allowed benefit after deductible 80% of allowed benefit after deductible Up to 3 attempts of IVF and/or Al p Not Covered	100% of allowed benefit 100% of allowed benefit ber live birth. Contact UnitedHealthcai	deductible 80% of allowed benefit after deductible 80% of allowed benefit after deductible re for further details and limitations. Not Covered	100% of allowed benefit
100% of allowed benefit 100% of allowed benefit	deductible 80% of allowed benefit after deductible 80% of allowed benefit after deductible Up to 3 attempts of IVF and/or Al p Not Covered	100% of allowed benefit 100% of allowed benefit per live birth. Contact UnitedHealthcar	deductible 80% of allowed benefit after deductible 80% of allowed benefit after deductible re for further details and limitations. Not Covered nandated by PPACA.	100% of allowed benefit 100% of allowed benefit
100% of allowed benefit 100% of allowed benefit 100% of allowed benefit 100% of allowed benefit	deductible 80% of allowed benefit after deductible 80% of allowed benefit after deductible Up to 3 attempts of IVF and/or AI p Not Covered Counseling and scn Not Covered	100% of allowed benefit 100% of allowed benefit ber live birth. Contact UnitedHealthcai 100% of allowed benefit eening for sexually active women as m 100% of allowed benefit	deductible 80% of allowed benefit after deductible 80% of allowed benefit after deductible re for further details and limitations. Not Covered anadated by PPACA. Not Covered botion contraceptives, refer to the Press	100% of allowed benefit 100% of allowed benefit 100% of allowed benefit 100% of allowed benefit
100% of allowed benefit 100% of allowed benefit 100% of allowed benefit 100% of allowed benefit	deductible 80% of allowed benefit after deductible 80% of allowed benefit after deductible Up to 3 attempts of IVF and/or AI p Not Covered Counseling and scr Not Covered Rg. IUD insertion and tubal ligation. For Both Scr	100% of allowed benefit 100% of allowed benefit ber live birth. Contact UnitedHealthcai 100% of allowed benefit eening for sexually active women as m 100% of allowed benefit	deductible 80% of allowed benefit after deductible 80% of allowed benefit after deductible re for further details and limitations. Not Covered nandated by PPACA. Not Covered 80% of allowed benefit after deductible	100% of allowed benefit 100% of allowed benefit 100% of allowed benefit 100% of allowed benefit
100% of allowed benefit 100% of allowed benefit 100% of allowed benefit 100% of allowed benefit Includes pre-conception counselii 100% of allowed benefit	deductible 80% of allowed benefit after deductible 80% of allowed benefit after deductible Up to 3 attempts of IVF and/or Al p Not Covered Counseling and scr. Not Covered 180% of allowed benefit after deductible Family planning benefits include: s 80% of allowed benefit after	100% of allowed benefit 100% of allowed benefit ber live birth. Contact UnitedHealthcar 100% of allowed benefit reening for sexually active women as n 100% of allowed benefit or information on coverage of prescrip 100% of allowed benefit	deductible 80% of allowed benefit after deductible 80% of allowed benefit after deductible re for further details and limitations. Not Covered anadated by PPACA. Not Covered botion contraceptives, refer to the Presc 80% of allowed benefit after deductible udiometrical biopsy and vasectomy. 80% of allowed benefit after	100% of allowed benefit 100% of allowed benefit 100% of allowed benefit 100% of allowed benefit ription Drug section of this guide. 100% of allowed benefit
100% of allowed benefit 100% of allowed benefit 100% of allowed benefit 100% of allowed benefit Includes pre-conception counselin 100% of allowed benefit 100% of allowed benefit	deductible 80% of allowed benefit after deductible 80% of allowed benefit after deductible Up to 3 attempts of IVF and/or Al p Not Covered Counseling and scr. Not Covered 80% of allowed benefit after deductible Family planning benefits include: s 80% of allowed benefit after deductible	100% of allowed benefit	deductible 80% of allowed benefit after deductible 80% of allowed benefit after deductible re for further details and limitations. Not Covered anandated by PPACA. Not Covered btion contraceptives, refer to the Presc 80% of allowed benefit after deductible udiometrical biopsy and vasectomy. 80% of allowed benefit after deductible	100% of allowed benefit 100% of allowed benefit 100% of allowed benefit 100% of allowed benefit rription Drug section of this guide. 100% of allowed benefit
100% of allowed benefit 100% of allowed benefit 100% of allowed benefit 100% of allowed benefit Includes pre-conception counselin 100% of allowed benefit 100% of allowed benefit	deductible 80% of allowed benefit after deductible 80% of allowed benefit after deductible Up to 3 attempts of IVF and/or AI p Not Covered Counseling and scr. Not Covered Not Covered 10g, IUD insertion and tubal ligation. Fe 80% of allowed benefit after deductible Family planning benefits include: s 80% of allowed benefit after deductible evisits, all lab services explicitly identit pre	100% of allowed benefit 100% of allowed benefit 200% of allowed benefit 300% of allowed benefit	deductible 80% of allowed benefit after deductible 80% of allowed benefit after deductible 80% of allowed benefit after deductible re for further details and limitations. Not Covered nandated by PPACA. Not Covered botion contraceptives, refer to the Presc 80% of allowed benefit after deductible udiometrical biopsy and vasectomy. 80% of allowed benefit after deductible gestational diabetes screening, tobac ions.	100% of allowed benefit 100% of allowed benefit 100% of allowed benefit 100% of allowed benefit rription Drug section of this guide. 100% of allowed benefit
100% of allowed benefit 100% of allowed benefit 100% of allowed benefit 100% of allowed benefit Includes pre-conception counselin 100% of allowed benefit 100% of allowed benefit	deductible 80% of allowed benefit after deductible 80% of allowed benefit after deductible Up to 3 attempts of IVF and/or Al p Not Covered Counseling and scr. Not Covered 180% of allowed benefit after deductible Family planning benefits include: s 80% of allowed benefit after deductible evisits, all lab services explicitly identif pre Radiology (i.e., obstetrical ultras	100% of allowed benefit	deductible 80% of allowed benefit after deductible 80% of allowed benefit after deductible 80% of allowed benefit after deductible re for further details and limitations. Not Covered nandated by PPACA. Not Covered botion contraceptives, refer to the Presc 80% of allowed benefit after deductible udiometrical biopsy and vasectomy. 80% of allowed benefit after deductible gestational diabetes screening, tobac ions.	100% of allowed benefit 100% of allowed benefit 100% of allowed benefit 100% of allowed benefit rription Drug section of this guide. 100% of allowed benefit
100% of allowed benefit 100% of allowed benefit 100% of allowed benefit 100% of allowed benefit Includes pre-conception counselin 100% of allowed benefit 100% of allowed benefit	deductible 80% of allowed benefit after deductible 80% of allowed benefit after deductible Up to 3 attempts of IVF and/or AI p Not Covered Counseling and scr. Not Covered Not Covered 10g, IUD insertion and tubal ligation. Fe 80% of allowed benefit after deductible Family planning benefits include: s 80% of allowed benefit after deductible evisits, all lab services explicitly identit pre	100% of allowed benefit 100% of allowed benefit 200% of allowed benefit 300% of allowed benefit	deductible 80% of allowed benefit after deductible 80% of allowed benefit after deductible 80% of allowed benefit after deductible re for further details and limitations. Not Covered nandated by PPACA. Not Covered 20% of allowed benefit after deductible udiometrical biopsy and vasectomy. 80% of allowed benefit after deductible gestational diabetes screening, tobac ions.	100% of allowed benefit 100% of allowed benefit 100% of allowed benefit 100% of allowed benefit rription Drug section of this guide. 100% of allowed benefit
100% of allowed benefit 100% of allowed benefit 100% of allowed benefit 100% of allowed benefit Includes pre-conception counselid 100% of allowed benefit 100% of allowed benefit Routine prenatal obstetrical office	deductible 80% of allowed benefit after deductible 80% of allowed benefit after deductible 80% of allowed benefit after deductible Up to 3 attempts of IVF and/or AI p Not Covered Counseling and scr. Not Covered 80% of allowed benefit after deductible Family planning benefits include: s 80% of allowed benefit after deductible e visits, all lab services explicitly identif pre Radiology (i.e., obstetrical ultras 80% of allowed benefit after deductible	100% of allowed benefit fied in the health reform law including gnant women, and certain immunizationulus) and high-risk prenatal service	deductible 80% of allowed benefit after deductible 80% of allowed benefit after deductible 80% of allowed benefit after deductible re for further details and limitations. Not Covered nandated by PPACA. Not Covered benefit after deductible adiometrical biopsy and vasectomy. 80% of allowed benefit after deductible gestational diabetes screening, tobac ions. ss may be subject to coinsurance. 80% of allowed benefit after deductible	100% of allowed benefit 100% of allowed benefit 100% of allowed benefit 100% of allowed benefit ription Drug section of this guide. 100% of allowed benefit 100% of allowed benefit co cessation counseling specific to
100% of allowed benefit 100% of allowed benefit 100% of allowed benefit 100% of allowed benefit Includes pre-conception counselii 100% of allowed benefit 100% of allowed benefit Routine prenatal obstetrical office 100% of allowed benefit	deductible 80% of allowed benefit after deductible 80% of allowed benefit after deductible 80% of allowed benefit after deductible Up to 3 attempts of IVF and/or AI p Not Covered Counseling and scr. Not Covered 10g, IUD insertion and tubal ligation. For allowed benefit after deductible Family planning benefits include: sj 80% of allowed benefit after deductible e visits, all lab services explicitly identify pre, Radiology (i.e., obstetrical ultras 80% of allowed benefit after deductible Includes delivery ser	100% of allowed benefit	deductible 80% of allowed benefit after deductible 80% of allowed benefit after deductible 80% of allowed benefit after deductible re for further details and limitations. Not Covered nandated by PPACA. Not Covered botion contraceptives, refer to the Presc 80% of allowed benefit after deductible udiometrical biopsy and vasectomy. 80% of allowed benefit after deductible gestational diabetes screening, tobac ions. sc may be subject to coinsurance. 80% of allowed benefit after deductible deductible sc stational diabetes screening tobac ions.	100% of allowed benefit
100% of allowed benefit 100% of allowed benefit 100% of allowed benefit 100% of allowed benefit Includes pre-conception counselii 100% of allowed benefit 100% of allowed benefit Routine prenatal obstetrical office 100% of allowed benefit	deductible 80% of allowed benefit after deductible 80% of allowed benefit after deductible 80% of allowed benefit after deductible Up to 3 attempts of IVF and/or AI p Not Covered Counseling and scr. Not Covered 10g, IUD insertion and tubal ligation. For allowed benefit after deductible Family planning benefits include: sj 80% of allowed benefit after deductible e visits, all lab services explicitly identify pre, Radiology (i.e., obstetrical ultras 80% of allowed benefit after deductible Includes delivery ser	100% of allowed benefit	deductible 80% of allowed benefit after deductible 80% of allowed benefit after deductible 80% of allowed benefit after deductible re for further details and limitations. Not Covered nandated by PPACA. Not Covered botion contraceptives, refer to the Presc 80% of allowed benefit after deductible udiometrical biopsy and vasectomy. 80% of allowed benefit after deductible g gestational diabetes screening, tobac ions. sr may be subject to coinsurance. 80% of allowed benefit after deductible tal care and services.	100% of allowed benefit
100% of allowed benefit 100% of allowed benefit 100% of allowed benefit 100% of allowed benefit Includes pre-conception counselii 100% of allowed benefit 100% of allowed benefit Routine prenatal obstetrical office 100% of allowed benefit	deductible 80% of allowed benefit after deductible 80% of allowed benefit after deductible 80% of allowed benefit after deductible Up to 3 attempts of IVF and/or AI p Not Covered Counseling and scr. Not Covered 10g, IUD insertion and tubal ligation. For allowed benefit after deductible Family planning benefits include: sj 80% of allowed benefit after deductible e visits, all lab services explicitly identify pre, Radiology (i.e., obstetrical ultras 80% of allowed benefit after deductible Includes delivery ser	100% of allowed benefit	deductible 80% of allowed benefit after deductible 80% of allowed benefit after deductible 80% of allowed benefit after deductible re for further details and limitations. Not Covered nandated by PPACA. Not Covered botion contraceptives, refer to the Presc 80% of allowed benefit after deductible udiometrical biopsy and vasectomy. 80% of allowed benefit after deductible gestational diabetes screening, tobac ions. sc may be subject to coinsurance. 80% of allowed benefit after deductible deductible sc stational diabetes screening tobac ions.	100% of allowed benefit
100% of allowed benefit Routine prenatal obstetrical office 100% of allowed benefit Covers the cost of rental/purchase ed) 525 copay when preauthorized by	deductible 80% of allowed benefit after deductible 80% of allowed benefit after deductible Up to 3 attempts of IVF and/or Al p Not Covered Counseling and scr Not Covered Roys of allowed benefit after deductible Family planning benefits include: si 80% of allowed benefit after deductible e visits, all lab services explicitly identif pre Radiology (i.e., obstetrical ultras 80% of allowed benefit after deductible Includes delivery ser Not Covered of certain breastfeeding equipment t 80% of allowed benefit after	100% of allowed benefit	deductible 80% of allowed benefit after deductible 80% of allowed benefit after deductible 80% of allowed benefit after deductible re for further details and limitations. Not Covered nandated by PPACA. Not Covered andated by PPACA. Not covered 80% of allowed benefit after deductible udiometrical biopsy and vasectomy. 80% of allowed benefit after deductible g estational diabetes screening, tobac ions. so may be subject to coinsurance. 80% of allowed benefit after deductible at may be subject to coinsurance. 80% of allowed benefit after deductible at care and services. Not Covered medical equipment partner(s). Conte	100% of allowed benefit
100% of allowed benefit Routine prenatal obstetrical office 100% of allowed benefit Covers the cost of rental/purchase ed) \$25 copay when preauthorized by the Plan	deductible 80% of allowed benefit after deductible 80% of allowed benefit after deductible 80% of allowed benefit after deductible Up to 3 attempts of IVF and/or AI p Not Covered Counseling and scr. Not Covered 100, IUD insertion and tubal ligation. Fe 80% of allowed benefit after deductible Family planning benefits include: s 80% of allowed benefit after deductible e visits, all lab services explicitly identif pre 80% of allowed benefit after deductible Includes delivery ser	100% of allowed benefit	deductible 80% of allowed benefit after deductible 80% of allowed benefit after deductible 80% of allowed benefit after deductible re for further details and limitations. Not Covered nandated by PPACA. Not Covered botion contraceptives, refer to the Presc 80% of allowed benefit after deductible udiometrical biopsy and vasectomy. 80% of allowed benefit after deductible gestational diabetes screening, tobac ions. se may be subject to coinsurance. 80% of allowed benefit after deductible tal care and services. Not Covered e medical equipment partner(s). Contail 80% of allowed benefit after deductible	100% of allowed benefit
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	None None None None None None None None	PPO PPO In-Network Out-of-Network None \$250 None \$5500 Any charges above the plan's \$250 None \$5500 Any charges above the plan's \$250 None \$5,000 S1,000 None \$6,000 S2,000 None Yes Yes Yes No No S5 S15 Copay Boy of allowed benefit after deductible deductible Denefit after deductible Denefit after deductible Birth through 36 months \$1,000 of allowed benefit after deductible Birth through 36 months \$1,000 of allowed benefit after deductible Denefit after deductib	In-Network None \$250 None \$500 None Any charges above the plan's Allowed Benefit are not counted towal None \$5,000 None	PPO POS POS POS POS POS POS POS POS POS

		UnitedHea	Ilthcare		
Benefit	PPO	PPO	POS	POS	EPO
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
HOSPITAL - INPATIENT SERVICES (Pr	eauthorization Required)	80% of allowed benefit after		80% of allowed benefit after	
Inpatient Care	100% of allowed benefit	deductible	100% of allowed benefit	deductible	100% of allowed benefit
		Inpatient care 80% of allowed benefit after	primarily for or solely for rehabilitatio	n is not covered. 80% of allowed benefit after	
Hospitalization	100% of allowed benefit	deductible 80% of allowed benefit after	100% of allowed benefit	deductible 80% of allowed benefit after	100% of allowed benefit
Anesthesia	100% of allowed benefit	deductible	100% of allowed benefit	deductible	100% of allowed benefit
Surgery	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Newborn Care****	Contact UnitedHealthcare to confirm	n your hospital's Neonatal Unit partici	pates in the plan. If the Neonatal Uni	t and its physicians do not participate	with the plan, you will be responsible
	for any balances up to the charge	of the Neonatal Unit's providers. The cover	PPO and POS plan will only pay these rage for these providers under the EPO		overage benefits. There will be no
	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Organ Transplant			•		
HOSPITAL - OUTPATIENT SERVICES	Вег	nefit is per calendar year for cornea, ki	dney, bone marrow, neart, neart-lung	, single or double lung, liver and panci	reas.
Chemotherapy/ Radiation	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Outpatient Surgery (Preauthorization	100% of allowed benefit	80% of allowed benefit after	100% of allowed benefit	80% of allowed benefit after	100% of allowed beliefit
Required)	100% of allowed benefit	deductible	100% of allowed benefit	deductible	100% of allowed benefit
Anesthesia	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
EMERGENCY TREATMENT	Í	least 5 H 11 St 5	ĺ	least 5 II II G: 5	
Urgent Care Centers	\$20 copay	80% of allowed benefit after deductible	\$20 copay	80% of allowed benefit after deductible	\$20 copay
	\$50 copy for ER Facility plus \$50 for	\$50 copy for ER Facility plus \$50 for	\$50 copy for ER Facility plus \$50 for	\$50 copy for ER Facility plus \$50 for	\$50 copy for ER Facility plus \$50 for
Emergency Room (ER) Services - Inside and outside of service area ***	ER Physician Services	ER Physician Services	ER Physician Services	ER Physician Services	ER Physician Services
	Copays are wa	sived if admitted; if criteria are not me	et for a medical emergency, plan cover	rage is 50% of allowed amount, after to	wo \$50 copays.
Ambulance Services - Emergency Transport	100% of allowed benefit	100% of allowed benefit	100% of allowed benefit	100% of allowed benefit	100% of allowed benefit
Ambulance Services - Non-Emergency		80% of allowed benefit after		80% of allowed benefit after	
Transport OTHER SERVICES & SUPPLIES (Preau	100% of allowed benefit thorization Required)	deductible	100% of allowed benefit	deductible	100% of allowed benefit
Acupuncture Services for Chronic Pain		80% of allowed benefit after	4000/ -5 - 11 11 54	80% of allowed benefit after	4000/ of allowed house?h
Management	\$20 copay	deductible	100% of allowed benefit	deductible	100% of allowed benefit Inpatient care: 100% of allowed
Behavioral Health	Not covered by UnitedHealthcare		s Section.	See Behavioral Health	benefit
		80% of allowed benefit after	1	80% of allowed benefit after	Outpatient care: \$15 copay
Cardiac Rehabilitation^	100% of allowed benefit	deductible	100% of allowed benefit	deductible	100% of allowed benefit
Chiropractic Services	\$20 copay	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Diagnostic Lab & X-Ray	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
		80% of allowed benefit after		80% of allowed benefit after	
Durable Medical Equipment	100% of allowed benefit	deductible	100% of allowed benefit	deductible	100% of allowed benefit
		80% of allowed benefit after	ontact Aetna for details on covered ite	ms. 80% of allowed benefit after	
Extended Care Facility (requires	100% of allowed benefit	deductible	100% of allowed benefit	deductible	100% of allowed benefit
preauthorization)	Skilled nursing care and extended ca	re facility benefits are limited to 180 o	days per benefit period as long as skille for rehabilitation is not covered.	ed nursing care is medically necessary.	Inpatient care primarily for or solely
Home Health Care (requires	100% of allowed benefit	80% of allowed benefit after		80% of allowed benefit after	4000/ - 6 - 11 1 1 5 2
preauthorization)	100% of allowed benefit	deductible Home Health	100% of allowed benefit Care benefits are limited to 120 days	deductible per plan year.	100% of allowed benefit
Hospice Care (requires preauthorization)	4000/ - F - II F F F	80% of allowed benefit after		80% of allowed benefit after	400% of allowed boar Ch
	100% of allowed benefit	deductible 80% of allowed benefit after	100% of allowed benefit	deductible 80% of allowed benefit after	100% of allowed benefit
Medical Supplies	100% of allowed benefit	deductible	100% of allowed benefit	deductible	100% of allowed benefit
	Includes, but not limited to, sur	gical dressings; casts; splints; syringes equipment and mach	; dressings for cancer, burns, or diabet ines; and all diabetic supplies as mano		exygen; supplies for renal dialysis
Outpatient Prescription Drugs			tely from Plan. See Prescription Drug		
Private Duty Nursing (requires		80% of allowed benefit after		80% of allowed benefit after	
preauthorization) Second Surgical Opinion (No	100% of allowed benefit	deductible	100% of allowed benefit	deductible	100% of allowed benefit
Preauthroization Required)	100% of allowed benefit	100% of allowed benefit 80% of allowed benefit after	100% of allowed benefit	100% of allowed benefit 80% of allowed benefit after	100% of allowed benefit
Whole Blood Charges (No Preauthroization Required)	100% of allowed benefit	deductible	100% of allowed benefit	deductible	100% of allowed benefit
VISION SERVICES & SUPPLIES Vision - Medical					
Any services that deal with the medical	\$15 copay (PCP) or \$25 copay	80% of allowed benefit after	\$15 copay (PCP) or \$25 copay	80% of allowed benefit after	\$15 copay (PCP) or \$25 copay
health of the eye.	(Specialists) Exam: Plan pays up to \$45 (available	deductible once every plan year)	(Specialists)	deductible	(Specialists)
				Single vision:	\$28.80
				Bifocal, single Bifocal, double	\$48.60 \$88.20
	Prescription lenses (per pair - availab	ole once every plan year):		Trifocal	\$70.20
Vision - Routine Any services that deal with correcting				Aphakic - glass Aphakic - plastic	\$54.00 \$126.00
vision.				Aphakic - aspheric	\$162.00
	Frames: Plan pays up to \$45 (availab	le once every plan year)		Medically Necessary	\$201.60
	Contacts (per pair, instead of frames	and lenses - available once every plan	year):	Cosmetic	\$50.40
	You may obtain vision services from	any licensed vision provider, whether			e full cost up front and submit a claim
See Footnote Tab for Medical Footnotes	<u>I</u>	form to UnitedHealthcare for pa	artial reimbursement. Contact United	nearchcare for more information.	
The state of the s					

SLEOLA (JANUARY 1, 2014 TO DECEMBER 31, 2014) BENEFIT CHART FOOTNOTES

* Immunizations: Covered immuninizations are determined by following the Immunization Schedules of the Centers for Disease Control and Prevention. Contact your plan for up-to-date information on covered immunizations. The immunization benefit Influenza (flu shots - one per plan year, regardless of age), Pneumococcal, HPV, Meningitis, and Shingles vaccines, immunizations required for participation in college admission, and Lyme Disease immunizations when medically necessary. Travel immunizations not covered.

***Emergency services or medical emergency is defined as: healthcare services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in: 1) placing the patient's health in jeopardy; 2) Serious impairment of bodily functions; or 3) Serious dysfunction of any bodily organ or part.

**** Newborns' and Mothers' Health Protection Act Notice. See page 68 of the July 1, 2013 to December 31, 2013Benefits Guide

^Cardiac rehabilitation benefits: 36 sessions in a 12-week period (or on a case-by-case basis thereafter) with physician supervision and in a medical facility. Cardiac rehabilitation must be medially necessary with a physician referral, and patient history of a heart attack in past 12 months; Coronary Artery Bypass Graft (CABG) surgery; angioplasty, heart valve surgery, stable angina pectoris, congestive heart failure; or heart and lunge transplants. Inpatient care primarily for rehabilitation is not covered.

^^ In-Vitro Fertilization (IVF) and Artificial Insemination (AI) benefits are available for a ligally married couple if: 1) There is a history of infertility throughout the most resent two years of marriage; 2) Her infertility is due to endometriosis, exposure in womb to diethylstilbestrol (DES), or blockage of or surgical removal of one or more fallopian tubes; or 3) Male infertility is the documented diagnostic cause.

The patient's oocytes must be fertilized with her spouse's sperm. IVF and AI are covered for a maximum of three attempts per procedure. Coverage of the three IVF attempts per live birth will not exceed a maximum expense of \$100,000 per lifetime. The AI attempts must be taken, when medically appropriate, before IVF attempts will be covered.

^^^ Habilitative Services, which include occupational therapy, physical therapy, and speech therapy, are covered for children under the age of 19 with congenital or genetic birth defects including but not limited to autism, autism spectrum disorder, and cerebral palsy.

Below are the resources used to determine the list of services that are covered with zero cost-share to our members:

Taken from the Federal Register, a group health plan must provide benefits for and prohibit cost sharing with respect to

- 1. Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF).
- 2. Immunizations that appear on the Immunization Schedules of the Centers for Disease Control and Prevention.
- 3. With respect to infants, children, adolescents, and women, preventive care and screenings provided for in the guidelines supported by the Health Resources and Services Administration (HRSA).

	DLA (JANUARY 1, 2014 TO DECEMBER 3: I Health Coverage for PPO and POS Plai	
Type of Service	In-Network Care	Out-Of-Network Care
npatient Facility and Professional Services	100% of allowed benefit when preauthorized by the Plan	80% of allowed benefit
Partial Hospitalization Services	100% of allowed benefit	80% of allowed benefit
Residential Crisis Services	100% of allowed benefit	80% of allowed benefit
Outpatient Facility	100% of allowed benefit	80% of allowed benefit
Office and Professional Services (excluding ntensive Outpatient Services)	\$15 copay	80% of allowed benefit
ntensive Outpatient Services	\$15 copay	80% of allowed benefit
Outpatient Medication Management Services	\$15 copay	80% of allowed benefit
<u>Plan Year Deductible</u>		
Individual	None	\$250
Family	None	\$500
	Combined with Medical	
Please Year Out-of-Pocket Coinsurance & Deductible Combined Maximum		
Individual	None	\$3,000
Family	None	\$6,000
	Combined with Medical	
<u>Plan Year Copyament Out-of-Pocket</u> <u>Maximum</u>		
Individual	\$1,000	None
Family	\$2,000	None
	Combined with Medical	
ifetime Maximum Beha v	Unlimi vioral Health Coverage for EPO Plan Par	
Type of Service	In-Network Care	Out-Of-Network Care
· ·	100% of the allowed benefit when	
npatient Facility and Professional Services	preauthorized by the Plan	No Out-Of-Network Coverage
Partial Hospitalization Services and		
Residential Crisis Services	100% of the allowed benefit	No Out-Of-Network Coverage
Outpatient Facility	100% of the allowed benefit	No Out-Of-Network Coverage
Office and Professional Services (excluding		
ntensive Outpatient Services)	\$15 copay	No Out-Of-Network Coverage
ntensive Outpatient Services	\$15 copay	No Out-Of-Network Coverage
Outpatient Medication Management Services	\$15 copay	No Out-Of-Network Coverage
<u>Plan Year Deductible</u>		
Individual	None	No Out-Of-Network Coverage
Family		No Out-Of-Network Coverage
Out-of-Pocket Coinsurance Maximum		N. 0. 1000 1. 1. 5
Individual	None	No Out-Of-Network Coverage
Family	None	No Out-Of-Network Coverage
<u>Plan Year Copyament Out-of-Pocket</u> <u>Maximum</u>		
Individual	\$1,000	No Out-Of-Network Coverage
Family	\$2,000	No Out-Of-Network Coverage
	Combined with Medical	
Lifetime Maximum	Unlimited	No Out-Of-Network Coverage

SLEOL	A (JANUARY 1, 2014 TO DECEMBER PRESCRIPTION DRUG BENEFITS	,	
	Copayments at Retail Pharmacie	S	
Type of Drug	Prescription for 1-45 Days (1 copay)	Prescription for 46-90 Days (2 copays)	
Generic drug	\$5	\$10	
Preferred brand name drug	\$15	\$30	
Non-preferred brand name drug	\$25	\$50	
Сорауг	nents through Voluntary Mail Orde	r Program	
Type of Drug	Prescription for 1-45 Days (1 copay)	Prescription for 46-90 Days (2 copays)	
Generic	\$5	\$10	
Preferred brand name	\$15	\$20	
Non-preferred brand name	\$25	\$20	
	Out-of-Pocket Maximum:		
Out-of-Pocket Maximum: This means that when the total amount of copays you and your covered depender during the plan year reaches \$350, you and your covered dependents will not pa more copays for eligible prescriptions for the remainder of the plan year.			